SECTION 6
BENEFITS AND LIMITATIONS

Missouri Statute 208.152 authorizes Medicaid coverage of emergency ambulance services. Only those transports considered an emergency and made to the *nearest appropriate hospital* are covered and should be submitted to Medicaid for payment. The definition for emergency transport is as follows:

> Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
> - ❖ Placing the recipient's health in serious jeopardy; or
> - ❖ Serious impairment to bodily functions; or
> - ❖ Serious dysfunction of any bodily organ or part.

"Nearest appropriate hospital" is the hospital equipped and staffed to provide the needed care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the service necessary to support the required medical care that determines whether it has appropriate facilities. The fact a more distant institution is better equipped, either qualitatively or quantitatively, to care for the recipient does not in itself support a conclusion a closer institution does not have appropriate facilities. Medicaid does not allow transportation to a more distant facility solely to avail a recipient of the services of a specific physician or family or personal preferences when considering the "nearest appropriate facility".

This policy can be found in section 13.3.A of the MO Medicaid Ambulance manual found on the DMS Web site, www.dss.mo.gov/dms. To access the manual, click on the Providers link on this page, then click on Provider Manuals at the bottom of the Provider Participation page. Exceptions to this policy can be found in sections 13.3.P, Healthy Children and Youth (HCY) services; 13.3.O, transfer of recipients to another hospital; and 13.3.L, transports for specialized testing.

Services not considered emergent or within the exempted categories should not be submitted to Medicaid for processing. Non-emergent trips, as well as services provided to a recipient not Medicaid eligible on the date of the transport, may be billed to the recipient. Medicaid recipients who dispute a bill from an ambulance provider may contact the Medicaid Recipient Services Unit (RSU) at 1-800-392-2161. It is not the responsibility of the ambulance provider to submit a claim to Medicaid in order to receive a denial before billing the recipient.

If the recipient contacts RSU regarding a bill, the ambulance provider may be contacted by RSU staff requesting a copy of the trip ticket. This documentation must be sent to RSU by the requested date in their letter. A medical consultant then reviews the trip

ticket. After review, both the ambulance provider and the recipient will receive written notification. If the review determines the transport meets the emergency criteria, the provider will be instructed to submit the claim to Medicaid and the recipient is not financially responsible. If the review determines the transport does not meet policy, the recipient is notified they are responsible for payment of the bill. **If the ambulance provider does not comply with RSU's request for documentation, the recipient is notified they are not responsible for payment of the bill.**

A list of non-covered ground and air ambulance services can be found in section 13.3.U of the Medicaid provider ambulance manual.

HEALTHY CHILDREN AND YOUTH (HCY) SERVICES

Missouri Medicaid covers medically necessary ambulance services for recipients under 21 years of age through the HCY program. Transport by ambulance is only covered if it is medically necessary and any other method of transportation would endanger the child's health. Examples include a child in a full body cast or having a tracheotomy requiring ventilatory assistance. A trip ticket documenting the ambulance trip was medically necessary must be attached to the claim form. HCY services are identified by the "EP" modifier. Any ambulance trip not meeting the emergency services definition according to Medicaid policy but is medically necessary for a recipient under 21 ***must*** use the "EP" modifier with the appropriate ambulance procedure code. Transports for the under 21 population meeting the definition of emergency services ***must not*** use the "EP" modifier.

If a recipient under 21 needs to be transported from one hospital to another for treatment or specialized testing and the transfer meets Medicaid policy (reference sections 13.3.L through 13.3.O of the Medicaid provider ambulance manual), the trip is a covered service. In these cases, the "EP" modifier is ***not*** used.

TRIP TICKET REQUIREMENTS

Effective February 1, 2006, the required submission of a trip ticket with the claim was removed under the following circumstances:

- Air ambulance transports;
- Transports for deceased individuals;
- Transports for multiple recipients; and
- Two trips in one day.

Providers are required to maintain all trip documentation in the recipient's file. As stated above, trip tickets for HCY services are required.

Ambulance providers who are on prepayment review must continue to file paper claims attaching the trip ticket and all appropriate and necessary documentation.

HOSPITAL TO HOSPITAL TRANSFERS

Ambulance transfers of recipients from one hospital to another hospital to receive inpatient medically necessary services not available at the first facility are covered by Medicaid. Hospital transfers shall be covered when the recipient has been stabilized at the first hospital, but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include services such as rehabilitation, a burn unit, ventilator assistance or other specialized care. ***Transport from a hospital capable of treating the recipient because the recipient and/or the recipient's family prefer a specific hospital or physician is not a covered service.***

TRANSPORTS TO TWO DIFFERENT HOSPITALS

Medicaid covers transportation from the point of pickup to two different hospitals made on the same day by the same ambulance provider when it is medically necessary. This situation happens when the ambulance transports to the nearest hospital, but before the recipient leaves the emergency room it is decided the first hospital is not appropriate and the recipient is transported to a second hospital. When it is medically necessary to transport a recipient from one hospital to another on the same date of service, providers must bill the base rate procedure code with a quantity of "2". Mileage and any ancillary charges for both trips are to be combined.

TWO TRIPS ON THE SAME DATE OF SERVICE

Two emergency ambulance trips to a hospital in one day for the same recipient may be covered when medically necessary. Proper trip documentation must be maintained in the recipient's record. To bill for two trips on the same day, the same provider must show a quantity of "2" units for the base rate procedure code. Mileage and any ancillary charges for both trips are to be combined. If one trip one trip is ALS (advanced life support) and one trip is BLS (basic life support), each trip should be billed on the same claim with the appropriate base rate procedure codes.

If two different ambulance services transport the same recipient on the same date of service, both providers must maintain proper trip documentation in the recipient's record to substantiate medical necessity.

TRANSPORT FOR SPECIALIZED TESTING

Transporting from one hospital to another hospital and return for specialized testing and/or treatment is covered for ground ambulance. One base charge is payable even though two separate trips or waiting time may be involved. The appropriate place of service when billing for specialized testing and/or treatment is 21 (inpatient hospital) since the hospital is both the point of pickup and final destination after receiving

services at the diagnostic or therapeutic site. Mileage may be billed if recipient transport from point of pickup to the destination and back is more than five miles. Use procedure code A0428HD to bill for transportation for specialized testing and/or treatment.

Transport from one medical facility to another for specialized testing and/or treatment is non-covered for emergency air ambulance services.

DECEASED RECIPIENTS

An individual is considered to have expired as of the time the individual is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician.

- If the recipient was pronounced dead *before* the ambulance was called, no Medicaid payment is made.
- If the recipient was pronounced dead *after* the ambulance was called but prior to arrival at the scene, payment may only be made for mileage from the base to the point of pickup. Transport from point of pickup to destination is not payable; the base rate is not reimbursable.
- If the recipient was pronounced after the ambulance arrived on the scene but prior to transport and life saving measures were performed at the scene, the base rate and mileage from base to point of pickup may be covered. ALS level 1 or 2 must be documented in the recipient's trip documentation (reference section 13.3.D of the Medicaid provider ambulance manual for ALS level 1 and 2 service definitions).
- If the recipient was pronounced dead while enroute to or upon arrival at the destination, the base rate and mileage from point of pickup to the destination may be covered. ALS level 1 or 2 must be documented in the recipient's trip documentation.

VALID AMBULANCE MODIFIERS

EP – HCY services for recipients under 21 years of age
GM – Ground transport for multiple recipients
HH – Hospital to hospital transfer
HD – Specialized testing and/or treatment

A complete list of covered procedure codes can be found in section 19 of the Medicaid provider ambulance manual.